Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Nutrition									
Do you breastfeed your baby?	Yes	No	Q1	Q1					
Do you breastfeed your child?	Yes	No			Q1				
Does your baby drink or eat 3 servings of calcium rich foods daily, such as formula, milk, cheese, yogurt, soy milk, or tofu?	Yes	No		Q2					
Does your child drink or eat 3 servings of calcium rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No			Q2	Q1	Q1	Q1	
Do you drink or eat 3 servings of calcium rich foods daily, such as milk, cheese, yogurt, soy milk, or tofu?	Yes	No							Q1
Does your child eat fruits and vegetables at least two times per day?	Yes	No			Q3	Q2	Q2	Q2	
Do you eat fruits and vegetables at least two times per day?	Yes	No							Q2
Does your child eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes			Q4	Q3	Q3	Q3	
Do you eat high fat foods, such as fried foods, chips, ice cream, or pizza more than once per week?	No	Yes							Q3
Does your child drink more than one small cup (4 - 6 oz.) of juice per day?	No	Yes			Q5	Q4	Q4		
Does your child drink more than one cup (8 oz.) of juice per day?	No	Yes						Q4	
Does your child drink soda, juice drinks, sports drinks, energy drinks, or other sweetened drinks more than once per week?	No	Yes			Q6	Q5	Q5	Q5	
Do you drink more than 12 oz. (1 soda can) per day of juice drink, sports drink, energy drink, or sweetened coffee drink?	No	Yes							Q4

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Physical Activity									
Does your child play actively most days of the week?	Yes	No			Q7	Q6			
Does your child exercise or play sports most days of the week?	Yes	No					Q6	Q6	
Do you exercise or play sports most days of the week?	Yes	No							Q5
Are you concerned about your baby's weight?	No	Yes	Q2	Q3					
Are you concerned about your child's weight?	No	Yes			Q8	Q7	Q7	Q7	
Are you concerned about your weight?	No	Yes							Q6
Does your baby watch any TV?	No	Yes	Q3	Q4					
Does your child watch TV or play video games?	No	Yes			Q9				
Does your child watch TV or play video games less than 2 hours per day?	Yes	No				Q8	Q8	Q8	
Do you watch TV or play video games less than 2 hours per day?	Yes	No							Q7
Safety									
Does your home have a working smoke detector?	Yes	No	Q4	Q5	Q10	Q9	Q9	Q9	Q8
Have you turned your water temperature down to low-warm (less than 120 degrees)?	Yes	No	Q5	Q6	Q11	Q10	Q10		
If your home has more than one floor, do you have safety guards on the windows and gates for the stairs?	Yes	No	Q6	Q7	Q12	Q11			

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	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Does your home have cleaning supplies, medicines, and matches locked away?	Yes	No	Q7	Q8	13	Q12			
Does your home have the phone number of the poison control center (800-222-1222) posted by your phone?	Yes	No	Q8	Q9	Q14	Q13	Q11	Q10	Q9
Do you always put your baby to sleep on her/his back?	Yes	No	Q9	Q10					
Do you always stay with your baby when she/he is in the bathtub?	Yes	No	Q10	Q11					
Do you always stay with your child when she/he is in the bathtub?	Yes	No			Q15	Q14			
Do you always place your baby in a rear facing car seat in the back seat?	Yes	No	Q11	Q12					
Do you always place your child in a rear facing car seat in the back seat?	Yes	No			Q16				
Do you always place your child in a forward facing car seat in the back seat?	Yes	No				Q15			
Do you always place your child in a booster seat in the back seat (or use a seat belt if your child is over 4'9")?	Yes	No					Q12		
Does your child always use a seat belt in the back seat (or use a booster seat if under 4'9").	Yes	No						Q11	
Is the car seat you use the right one for the age and size of your baby?	Yes	No	Q12	Q13					
Is the car seat you use the right one for the age and size of your child?	Yes	No			Q17	Q16			
Do you always wear a seatbelt when riding in a car?	Yes	No							Q10
Do you always check for children before backing your car out?	Yes	No			Q18	Q17			

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Does your baby spend time near a swimming pool, river, or lake?	No	Yes		Q14					
Does your child spend time near a swimming pool, river, or lake?	No	Yes			Q19	Q18	Q13	Q12	
Does your baby spend time in a home where a gun is kept?	No	Yes	Q13	Q15					
Does your child spend time in a home where a gun is kept?	No	Yes			Q20	Q19	Q14	Q13	
Do you spend time in a home where a gun is kept?	No	Yes							Q11
Does your child spend time with anyone who carries a gun, knife, or other weapon?	No	Yes					Q15	Q14	
Do you spend time with anyone who carries a gun, knife, or other weapon?	No	Yes							Q12
Does your child always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No			Q21	Q20	Q16	Q15	
Do you always wear a helmet when riding a bike, skateboard, or scooter?	Yes	No							Q13
Has your child ever witnessed or been a victim of abuse or violence?	No	Yes				Q21	Q17	Q16	
Have you ever witnessed abuse or violence?	No	Yes							Q14
Have you been hit, slapped, kicked, or physically hurt by someone (or have you hurt someone) in the past year?	No	Yes							Q15
Has your child been hit or has your child hit someone in the past year?	No	Yes					Q18	Q17	

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Has your child ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes					Q19	Q18	
Have you ever been bullied, felt unsafe at school or in your neighborhood (or been cyber-bullied)?	No	Yes							Q16
Dental									
Do you give your baby a bottle with anything in it except formula, milk, or water?	No	Yes	Q14	Q16					
Do you help your child brush and floss her/his teeth daily?	Yes	No			Q22	Q22			
Does your child brush and floss her/his teeth daily?	Yes	No					Q20	Q19	
Do you brush and floss your teeth daily?	Yes	No							Q17
Mental Health									
Does your child often seem sad or depressed?	No	Yes					Q21	Q20	
Do you often feel sad, down, or hopeless?	No	Yes							Q18
Alcohol, Tobacco, Drug Use (Tobacco Exposure)									
Does your baby spend time with anyone who smokes?	No	Yes	Q15	Q17					
Does your child spend time with anyone who smokes?	No	Yes			Q23	Q23	Q22	Q21	
Do you spend time with anyone who smokes?	No	Yes							Q19
Has your child ever smoked cigarettes or chewed tobacco?	No	Yes						Q22	
Do you smoke cigarettes or chew tobacco?	No	Yes							Q20

Pediatric Questions by Age Group

	Responses Do Not Require Follow-Up	Responses Require Follow-Up	Months		Pediatric				
			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Are you concerned your child may be using or sniffing substances, such as glue, to get high?	No	Yes						Q23	
Do you use or sniff any substance to get high, such as marijuana, cocaine, crack, methamphetamine (meth), ecstasy, etc.?	No	Yes							Q21
Do you use medicines not prescribed for you?	No	Yes							Q22
Are you concerned that your child may be drinking alcohol, such as beer, wine, wine coolers, or liquor?	No	Yes						Q24	
Do you drink alcohol once a week or more?	No	Yes							Q23
If you drink alcohol, do you drink enough to get drunk or pass out?	No	Yes							Q24
Does your child have friends or family members who have a problem with drugs or alcohol?	No	Yes						Q25	
Do you have friends or family members who have a problem with drugs or alcohol?	No	Yes							Q25
Do you drive a car after drinking, or ride in a car driven by someone who has been drinking or using drugs?	No	Yes							Q26
Sexual Issues									
Has your child started dating or "going out" with boyfriends or girlfriends?	No	Yes					Q26		
Do you think your child might be sexually active?	No	Yes					Q27		
Have you ever been forced or pressured to have sex?	No	Yes							Q27
Have you ever had sex (oral, vaginal, anal)? *If no, skip to question 35.*	No	Yes							Q28

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			0–6	7–12	1–2	3–4	5–8	9–11	12–17
Do you think you or your partner could have a sexually transmitted infection (STI), such as Chlamydia, Gonorrhea, genital warts, etc.?	No	Yes							Q29
Have you or your partner(s) had sex with other people in the past year?	No	Yes							Q30
Have you or your partner(s) had sex without using birth control in the past year?	No	Yes							Q31
The last time you had sex, did you use birth control?	Yes	No							Q32
Have you or your partner(s) had sex without a condom in the past year?	No	Yes							Q33
Did you or your partner use a condom the last time you had sex?	Yes	No							Q34
Do you have concerns about liking someone of the same sex?	No	Yes							Q35
Last Question (Open Ended)									
Do you have any other questions or concerns about your baby's health, development, or behavior? If yes, please describe:	No	Yes	Q16	Q18					
Do you have any other questions or concerns about your child's health, development, or behavior? If yes, please describe:	No	Yes			Q24	Q24			
Do you have any other questions or concerns about your child's health or behavior? If yes, please describe:	No	Yes					Q23	Q28	
Do you have any other questions or concerns about your health? If yes, please describe:	No	Yes							Q36
Question Totals per Age Group			16	18	24	24	23	28	36